Flexible Spending Account Enrollment

King County
Benefits and Retirement Operations

Complete this form to enroll in a Health Care FSA, Dependent Care FSA or both. Return the form to Benefits and Retirement Operations, Exchange Building EXC-ES-0300, 821 Second Ave., Seattle WA 98104-1598 *within 30 days of when your other benefits begin*. To have FSA reimbursements direct deposited, go to www.personalchoiceaccount.com/documents/Employee_Direct_Deposit_Form.pdf or call Personal Choice Account (PCA) at 1-800-334-4340.

Name (print)_____ PeopleSoft Employee ID _____

Street Address or PO Box _____

City _____ State _____ ZIP _____

E-mail _____ Contact Phone (_____)_____

Paid ☐ 5th and 20th each month ☐ Every other Thursday

Effective date (*eligibility date verified by Benefits and Retirement Operations*)

☐ Please make effective when I'm eligible (mo/yr) _____ ☐ This is my annual re-enrollment (yr) _____

Health Care FSA

Please check yes if you elect to participate and indicate the total amount you'd like deducted for the year. The minimum you may contribute is $300; the maximum may not exceed $6,000 annually. Whether you're paid 24 or 26 times per year, a maximum of 24 payroll deductions will be taken. The per paycheck deduction amount is determined by the date your enrollment is processed and made effective.

☐ Yes, I elect to participate. Please deduct a total of $ _____ PER YEAR from my paychecks in 200_____.

Dependent Care FSA

Please check yes if you elect to participate and indicate the total amount you'd like deducted for the year. The minimum you may contribute is $300; the maximum may not exceed: 1) the lower of husband's or wife's earned income, 2) $5,000 annually if married filing jointly or head of household or 3) $2,500 annually if married filing separately. Whether you're paid 24 or 26 times per year, a maximum of 24 payroll deductions will be taken. The per paycheck deduction amount is determined by when your enrollment is processed and made effective.

☐ Yes, I elect to participate. Please deduct a total of $ _____ PER YEAR from my paychecks in 200_____.

Authorization

I authorize King County to withhold a portion of my pre-tax employment compensation and deposit these funds to the FSA(s) I've designated above. In consideration of King County allowing me to participate in the plan, I agree to abide by the terms, conditions and provisions of the plan contained in the county's plan document. I have been informed the plan may be modified from time to time and I agree King County may cancel or amend the plan according to its independent judgment and discretion. I understand I will be notified in advance of any changes. I acknowledge my right to examine the plan document or obtain a copy of it by giving reasonable advance notice to the plan administrator and paying a reasonable copy cost.

I acknowledge the Internal Revenue Code and the plan permit me to claim reimbursement only for my eligible expenses incurred after the effective date of my FSA elections. I understand the Internal Revenue Code prohibits me from claiming the Federal Child Care Tax Credit for dependent care assistance expenses which are reimbursed to me by the plan. I assume full responsibility for all taxes, penalties, interest or other consequences, which may be assessed to or imposed on me by any state, federal or other governmental taxing authority as a result of my requesting and receiving reimbursements from the plan for disallowed expenses.

I choose to participate in the FSA Program with the knowledge that my salary reduction elections may reduce my FICA withholdings (Social Security) and this may reduce my Social Security benefits upon retirement.

I understand I must claim reimbursement for eligible expenses incurred during the calendar year on or before 90 days after the last day of the calendar year or I will forfeit those reimbursements. I further acknowledge I will forfeit all funds credited to my FSAs, which are not reimbursed to me.

I understand the total amount I have requested will be deducted for the year I have indicated, but my per paycheck deduction amount will be determined by when my enrollment is processed and made effective.

Signature _____ Date Signed _____

Office Use Only	Received Date Staff Name	Eligibility Verified Date Staff Name	Copy to AAI Date Staff Name	FSA Effective Date